

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

PROPOSED DECISION

RH—04036604

In the Matter of: Proposed adoption of the Insurance Commissioner's regulations pertaining to pure premium rates for workers' compensation insurance, to be effective on July 1, 2004.

A Notice of Proposed Action and Notice of Public Hearing, File Number RH—04036604, dated April 1, 2004, was submitted to the Office of Administrative Law, published in the California Notice Register, and mailed to interested parties. The Notice is included in the record. The Notice summarized the proposed changes and recited that a summary of the information submitted by the Insurance Commissioner in connection with the proposed changes was available to the public. In addition, the "Filing Letter" dated April 29 and May 13, 2004 submitted by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) and related documents were available for inspection by the public at the San Francisco and Los Angeles offices of the Department of Insurance and were also available for inspection on the WCIRB website at www.wcirbonline.org.

Testimony from the WCIRB and others, written and oral, was taken at hearings in San Francisco on April 29 and May 13, 2004 and exhibits were received into the record. The hearing panel included Insurance Commissioner John Garamendi and Senior Actuaries Ronald Dahlquist and Eric Johnson. Senior Staff Counsel Larry C. White was the hearing officer.

The matter was submitted for decision at the conclusion of the hearing, subject to the record remaining open for additional written comments received at the San Francisco office of the Department of Insurance by 5 P.M. on May 17, 2003. The matter having been duly heard and considered, the following Proposed Decision and Proposed Order are hereby made.

EXPLANATION AND HISTORY

The matters considered at the hearing consisted of proposed changes in the regulations of the Insurance Commissioner regarding workers' compensation pure premium rates. In addition, the WCIRB has proposed changes in the Uniform Statistical Reporting Plan—1995 and the California Workers' Compensation Experience Rating Plan—1995. The new regulations will apply to new and renewal policies with anniversary rating dates on or after July 1, 2004.

The changes in the regulations were proposed to the Insurance Commissioner in two letters with attachments dated April 29 and May 13, 2004, submitted by the Workers' Compensation Insurance Rating Bureau of California, a licensed workers' compensation insurance rating organization.

The Bureau's filing proposed pure premium rates that reflect projected insurer loss costs and loss adjustment expenses including the effect of workers' compensation reform legislation enacted to date.

THE ADOPTED PURE PREMIUM AND ITS DETERMINATION

Pure premium rates approved by the Insurance Commissioner reflect only loss costs, including loss adjustment expenses; they do not include any provision for general expenses, commissions, other acquisition expenses, premium taxes, or profits. Although the commissioner's pure premium rates are not mandatory in themselves, Insurance Code Section 11735.1 requires that the reduction in pure premium that the commissioner has calculated is due to reform legislation enacted in the 2003-2004 Regular Session of the legislature must be reflected in insurer rate filings and that reduction must be passed through to policyholders.

The Bureau has proposed a decrease in pure premium rates from the January 1, 2004 approved pure premium rates of 2.9% to be effective for new and renewal policies with anniversary rating dates on or after July 1, 2004. Thus, the WCIRB is proposing a decrease of 17.4% from July 1, 2003 approved pure premium rates. For reasons detailed below, the Department adopts an average decrease of 7% from the January 1, 2004 approved pure premium rates, resulting in an average decrease from July 1, 2003 rates of 20.9% for new and renewal policies with anniversary rating dates on or after July 1, 2004.

Basic Ratemaking Methodology

Paid Medical Loss Development Factors

In our decision on the January 1, 2004 advisory pure premium, we rejected the WCIRB's proposed methodology for trending the paid medical loss development factors. In this filing, the WCIRB uses the same method and we reject it again.

We previously rejected the proposed method because it crosses the line in the actuarial trade-off between stability and responsiveness and because the use of just three points to fit a curve is inherently unreliable and unsound. The WCIRB has offered no new information or argument to change our decision.

We note in passing that the five-year trended factor for the latest year is actually slightly higher than the three-year trended factor. This is mostly due to the latest observation, the

12-24 month factor for accident year 2002, actually being lower than the 12-24 month factor for accident year 2001.

Trending of the Indemnity Pure Premium Ratio

In our decision on the January 1, 2004 advisory pure premium, we rejected the WCIRB's proposed methodology for projecting the indemnity pure premium ratio, namely, using the average of the latest three years. Instead, we substituted the latest year's ratio. In this filing, the WCIRB uses the same method and we reject it again.

The indemnity claim experience from the latest year, accident year 2003, is affected by the partial repeal in Assembly Bill 749 of the treating physician presumption. As we noted in our last decision, this presumption extended beyond medical benefits and affected indemnity benefits as well, as when the physician determines the degree of impairment. The WCIRB made an estimate of the effect on medical benefits but neglected to estimate an effect on indemnity benefits.

Going forward, we expect future indemnity experience to be more like the accident year 2003 experience than like the earlier accident years.

Effect of Increased Indemnity Benefits on Medical Losses

In our decision on the January 1, 2004 advisory pure premium, we rejected the WCIRB's proposed methodology for adjusting medical costs for increased utilization due to changes in indemnity benefits. In this filing, the WCIRB uses the same method and we reject it again.

Our previous two decisions discuss our reasoning for rejecting the loading and we incorporate those discussions here by reference. The WCIRB has offered no new information or reasoning here to change our decision.

Allocated Loss Adjustment Expense

In this filing the WCIRB proposes to use the same method for allocated loss adjustment expense (ALAE) that they used and which we approved for the January 1, 2004 filing. We cannot approve the method for this filing because the continuing changes due to the various reform legislations have highlighted the weaknesses of the method.

The proposed method averages the results of two calculations. The first calculation derives development factors from a triangle of actual paid ALAE dollars, then applies the development factors to the ALAE-to-premium ratio, which is then converted to a ALAE-loss ratio. The second calculation derives development factors from a triangle of paid-ALAE-to-paid-indemnity ratios. The ultimate ALAE-to-indemnity ratios are then adjusted for changes in indemnity benefit levels and then trended forward.

The upward trend is much more pronounced in the second calculation because the proportion of indemnity losses to total losses has diminished over time, as indemnity losses have remained relatively moderate while medical losses have spiraled out of control.

In the reform environment we are now in, we expect that the upward spiral in medical costs will cease and the ratio between indemnity and medical dollars will stabilize. Thus, the second calculation is rendered faulty. More generally, it is more reasonable to assume that ALAE is a function of total loss dollars rather than of indemnity dollars or of medical dollars alone.

Instead, we substitute for the second calculation one based on a ratio of total paid dollars, rather than just paid indemnity dollars. We also make a further change to the second calculation by removing the on-current-benefit-level adjustment. The assumption underlying this adjustment would appear to be that ALAE dollars will remain fixed, regardless of the level of benefits. There appears to be no basis for such an adjustment. It would also appear that, based on the timing of benefit changes, including the adjustment in the calculation could lead to either an overstatement or understatement of the true ALAE need.

2004 Reform Legislation

Limitation on Temporary Disability

Senate Bill 899 amends Labor Code Section 4656(c) to limit temporary disability payments to “104 compensable weeks within a period of two years from the date of commencement of first temporary disability payment.” For some specific injuries, the limit is 240 weeks within a five year period. The amendment applies to injuries occurring on or after April 19, 2004.

The WCIRB estimates the savings by making two adjustments to its basic benefit model. First, they reduce the average temporary disability duration by about 15%. This adjustment is based on a study by the California Workers Compensation Institute, which shows that 16.1% of all temporary disability benefits are currently paid more than two years after the first payment date and that 9.4% of all temporary disability benefits are made for the specific injuries excepted from the cap.

Second, the WCIRB reduces the average weekly benefit by 0.7%. This adjustment is based on the impact of the amendment on Labor Code Section 4661.5, which provides that benefits paid two years after injury will receive the higher of the benefit amount in effect at time of payment and the amount in effect at time of injury. By limiting payments to 104 weeks, the amendment to 4656(c) essentially eliminates any impact from 4661.5.

The result is a 15.2% savings on temporary disability benefits, which translates to a 2.6% savings in total benefit costs.

Mr. Neuhauser's estimate is identical to that of the WCIRB. Since there is no disagreement about the savings, we adopt the WCIRB's estimate.

Changes Relating to Permanent Disability

Permanent Disability Schedule

SB 899 requires the Administrative Director of the State Division of Workers Compensation to adopt regulations by January 1, 2005 to implement a new Permanent Disability Schedule. This new schedule is to reflect definitions of physical injury or impairment based on the American Medical Association Guides to the Evaluation of Permanent Impairment (5th Edition), modified due to the age and occupation of the injured worker, and is to incorporate estimates of the injured worker's diminished earning capacity taken from the latest RAND study.

The WCIRB has declined to estimate an effect for this schedule because of the uncertainty with regard to both its content and structure, and its actual future implementation date.

Mr. Neuhauser, representing CHSWC, testified that the AMA Guides should be expected to eliminate many claims that are currently awarded permanent disability based solely on prophylactic work restrictions that are prescribed by the treating physician. He estimated that 33% of all permanent disability claims would be eliminated by the new schedule. This would result in a reduction in the overall advisory pure premium rate of about 8%.

Mr. Fred Kilbourne, the actuary representing the Public Members, argued for a reduction of 10% of permanent disability losses due to the new schedule. This would amount to about a 2% reduction in total costs.

Jacqueline Schauer, testifying on behalf of Andrea Hoch, the newly appointed Administrative Director of the State Division of Workers Compensation, stated that Ms. Hoch was dedicated to producing the required new Permanent Disability Schedule by January 1, 2005 as required by law. Ms. Schauer also pointed out, however, that the Division of Workers Compensation is severely impacted by a shortage of staff resources. She further testified that the Division of Workers Compensation was in the beginning stages of work on this project, and did not have a preconceived notion as to whether the new Permanent Disability Schedule would result in decreased or increased benefit costs, or whether it would be cost-neutral.

We are inclined to believe Mr. Neuhauser's assertions that the new schedule is likely to result in significant savings, as this was the apparent expectation of the proponents of the legislation. We do express some doubt as to the ability of the Division of Workers Compensation to complete the task of building the new Permanent Disability Schedule by

January 1, 2005, given the apparent complexities of the task and the Division's limited resources. In the final analysis, we accept the Bureau's assertion that it is premature to estimate the savings that will eventually be attributable to the revised Permanent Disability Schedule, since wide variation in its content and effective date are possible.

We do note that, if the schedule is produced on time, and does result in significant savings, it would be appropriate to pass these savings on to the policyholders in the form of a rate reduction applicable to all policies outstanding as of January 1, 2005. We expect that the WCIRB will evaluate the appropriate advisory pure premium reduction applicable to policies outstanding as of January 1, 2005, if the new Permanent Disability Schedule is completed prior to the Bureau's January 1, 2005 advisory pure premium rate filing. Insurers that adopt the WCIRB's reduction may reduce premiums accordingly.

Change in the Number of Weeks of Permanent Disability Benefits Establishment of Two-Tiered Permanent Disability Benefits

The WCIRB also chose not to attribute any effect to the change in the schedule of the number of weeks of permanent disability to be awarded based on the percentage of permanent disability, or to the new two-tiered permanent disability payment system. The WCIRB points out that the language of SB 899 makes these provisions effective when the new permanent disability schedule becomes effective. Given that the implementation date and the form and effect of the new permanent disability schedule are uncertain, the WCIRB argues that it is premature to attempt to attribute an effect to either of these two provisions.

The WCIRB did estimate that if the new permanent disability schedule did not change the distribution of permanent disability ratings, the impact of the change in weeks of permanent disability would be a reduction in overall system costs of -2.5%, and the impact of the two-tiered benefit structure would be a reduction in overall system costs of about -0.8%.

We note that the WCIRB's calculations of these savings are relatively straightforward, and we believe that the savings are very likely to be achieved once these provisions become effective. However, the effective date of these provisions is uncertain because it is dependent on the effective date of the new permanent disability schedule. We believe there is simply too much uncertainty regarding when the Division of Workers Compensation will be able to complete the task of developing the schedule. Accordingly, we do not believe it is appropriate to include in the pure premium rates an estimate of the impact of either the change in weeks of permanent disability payments or the two-tiered permanent disability benefit structure. In this matter, also, we expect that the WCIRB will evaluate the appropriate advisory pure premium reduction applicable to policies outstanding as of January 1, 2005, if the new Permanent Disability Schedule is completed prior to the Bureau's January 1, 2005 advisory pure premium rate filing.

Apportionment

SB 899 requires that the injured worker's disability be apportioned based on causation, and that all physician reports determine the percentage of the injured worker's permanent disability that was caused by the direct effect of the injury arising out of employment and the percentage that is caused by other factors, including prior injuries. The new law states that the employer is only liable for the percentage of the permanent disability directly caused by the injury arising out of employment. It further states that if the injured employee had previously received a permanent disability award, the disability shall be conclusively presumed to exist at the time of the subsequent injury. Finally, it states that the cumulative percentage of disability for any one region of the body cannot exceed 100%, unless the injury is determined to be total. These provisions are effective on April 19, 2004, the date the Bill was signed into law.

The WCIRB estimates that approximately 10% of all permanent disability awards will be eliminated due to the apportionment provisions of SB 899. The WCIRB estimates the effect of the apportionment provisions to be a 3.1% reduction of overall system costs. CHSWC appears to be in agreement with this estimate.

We find the Bureau's logic to be reasonable, but we modify the Bureau's estimated effect in two respects.

First, the WCIRB, following its standard practice, has included a utilization effect on both the medical and indemnity costs associated with the apportionment provisions. The Bureau essentially assumes that the reduced permanent partial disability benefits will result in a reduction in claim frequency, and thus a reduction in both medical and indemnity benefits. In order to maintain consistency with our view of the utilization issue, we accept the utilization impact on the indemnity side, but reject it on the medical side. This has the effect of reducing the Bureau's estimate of savings due to apportionment by 0.5%.

Second, Mr. Neuhauser has pointed out that life pension cases can be affected by apportionment as well. We agree that some provision for savings due to the effect of apportionment on life pension cases is appropriate. Mr. Neuhauser observes that the indemnity payments on permanent total disability and life pension cases account for about 3% of total system costs. Applying the 10% reduction factor, he gets a savings estimate of about 0.3% of total system costs. The WCIRB has responded that they have not had the opportunity to adequately study this issue, but they expect the effect would be minimal since they believe the great majority of permanent total and life pension cases to be due to severe traumatic injuries that would not be subject to apportionment.

Based on our review of the WCIRB's filing materials, we observe that indemnity payments on permanent total disability and life pension cases appear to account for about 4.25% of total system costs. Since we believe there is merit in both arguments, and insufficient information to prove either, we approve a savings estimate that is 5% of the permanent total disability and life pension indemnity costs, or 0.2% of total system costs.

We approve a savings estimate for the apportionment provisions of 2.8% of total system costs (3.1% - 0.5% + 0.2%.)

Changes to Medical Treatment

Changes effective April 19, 2004

Several changes made to Labor Code Sections 4600 and 4604.5 generally strengthen the legal standing of medical treatment decisions made in accordance with the ACOEM Guidelines and the Official Utilization Schedule to be produced by the Administrative Director of the Division of Workers Compensation. These provisions define “treatment reasonably necessary to cure and relieve” to mean treatment in accordance with the ACOEM Guidelines; specify that the Utilization Schedule shall be evidence-based; give the ACOEM Guidelines and the subsequent Utilization Schedule the presumption of correctness; make that presumption rebuttable only by a preponderance of the scientific medical evidence; and make the presumption of correctness a presumption affecting the burden of proof.

Changes effective January 1, 2005

Once the Administrative Director of the Division of Workers Compensation establishes regulations, insurers and self-insured employers may establish medical provider networks. Once these networks are approved by the Administrative Director, the insurer or self-insured employer can require the injured worker to obtain treatment from a doctor within the network. This employer control lasts for the life of the claim. The injured worker may change doctors a maximum of two times, but each doctor must be a member of the network. Disputes over the appropriateness of treatment must be resolved by an independent medical review process to be set up and managed by the Administrative Director, using the ACOEM Guidelines or the subsequent Official Utilization Schedule to be developed by the Administrative Director.

Evaluation of the Effects of the Changes

We agree with the WCIRB that it is difficult to assess the separate impacts of all of the law changes relating to utilization of medical services that have been enacted in AB 749, AB 227, SB 228, and SB 899. As we did in our Proposed Decision on the WCIRB’s advisory pure premium rate filing effective January 1, 2004, we prefer to utilize the structure proposed by Mr. Frank Neuhauser of the UC Berkeley Survey Research Center to evaluate these provisions on a combined basis. Because some provisions became effective immediately upon passage of SB 899 on April 19, 2004, while others will become effective on January 1, 2005, we have estimated separate effects for the two groups of changes.

Previous Evaluation of AB 227 and SB 228

In our Proposed Decision on the January 1, 2004 filing, we accepted Mr. Neuhauser's premise that California Workers Compensation has a medical cost level that is 2.5 times as great as that of group health fee-for-service plans. This implies that 60% of the portion of the workers compensation advisory pure premium attributable to medical benefits represents excess cost. We assumed that California Workers Compensation had a 12% excess pricing "premium", which represented 4.8% of the medical portion of the pure premium. This left 55.2% of the medical portion of the pure premium as excess cost attributable to over-utilization of medical services.

In our Proposed Decision, we assumed that the ACOEM Guidelines had the potential to eliminate two thirds of the excess cost, or 36.8% of the medical portion of the pure premium. We were convinced, however, that there was considerable uncertainty as to how the ACOEM Guidelines would be interpreted by Administrative Law Judges, and as to whether the Guidelines could be successfully rebutted on a case-by-case basis. Accordingly, we assumed the Guidelines would be only 50% effective in practical application, thus reducing the estimated effect to an 18.4% reduction in medical costs.

We made further adjustments to avoid double-counting the benefits already attributed to the repeal of the treating physician's presumption of correctness in AB 749, and to the limits on chiropractic and physical therapy visits enacted as part of SB 228. We also reduced the assumed effect for the expected delay in the publishing of the ACOEM Guidelines, and the presumption that the Guidelines would never apply to medical treatments representing 10% of medical costs.

The net impact of our analysis in the Proposed Decision was to attribute additional savings of 7.2% of medical benefits, or 4.0% of the total advisory pure premium, to the effect of the Guidelines that wasn't already attributed to the repeal of the treating physician's presumption or the limits on chiropractic and physical therapy visits. The Commissioner subsequently adopted an advisory pure premium level that was based on additional savings due to the ACOEM Guidelines of 10.1% of medical benefits, or 6.0% of the total advisory pure premium. In his Decision, the Commissioner anticipated that "cleanup" legislation would be passed that would allow the ACOEM Guidelines a greater degree of effectiveness in the legal arena.

Analysis of Changes Effective April 19, 2004

We first evaluate the likely effect of the "cleanup" legislation relating to the ACOEM Guidelines that was effective April 19, 2004.

We agree that the new provisions in the law will be likely to improve the effectiveness of the ACOEM Guidelines and their eventual successor, the Administrative Director's Official Utilization Schedule. We have chosen to increase our effectiveness assumption to 80% from the 50% we had previously used in the evaluation of the January 1, 2004 filing. This increases our estimated reduction in over-utilization of medical services from

the previous estimate of 18.4% to our new estimate of 29.4%. We have eliminated our reduction for the delayed implementation of the ACOEM Guidelines, since the Guidelines became effective in late March, and the new advisory pure premiums will apply to policies issued on or after July 1, 2004.

However, based on our interpretation of the testimony presented by Mr. Alex Swedlow of the California Workers Compensation Institute, we are now assuming that 20% of medical dollars will be for procedures that are outside the ACOEM Guidelines. Our previous estimate was 10%. This reduces the estimated reduction in over-utilization of medical services from 29.4% to our new estimate of 23.6%. We also remove 2.2% of the medical advisory pure premium to avoid double-counting the effect of the limits on chiropractic and physical therapy visits; 7.4% for the filed effect of the AB 749 repeal of the primary treating physician's presumption of correctness; and 10.1% for the Commissioner's assumed effect of the ACOEM Guidelines. The net result is an additional savings of 3.9% of the medical portion of the advisory pure premium rate, or 2.3% of the overall advisory pure premium rate.

Analysis of Changes effective January 1, 2005

We believe the new provisions of law relating to the establishment of employer or insurer-controlled networks, coupled with the new independent medical review approach to resolving disputes, will have a very significant impact on medical costs in California Workers Compensation. We believe these provisions will increase the potential reduction in over-utilization to 80%, with 90% effectiveness. This would allow the "utilization premium", estimated at 55.2% of the medical pure premium, to be reduced by 72%. This produces a combined savings of 39.7%. Reducing this by 20% for the recognition that not all medical procedures will be covered by the Guidelines, the combined savings is reduced to 31.8%. Again removing the same effects of the chiropractic and physical therapy visits, the repeal of the primary treating physician presumption, and the Commissioner's evaluation of the effect of the Guidelines, and also removing the 3.9% effect attributable to the SB 899 "cleanup" legislation, we arrive at a reduction effect of 8.2% of the medical portion of the advisory pure premium rate. Since these provisions will not be effective until January 1, 2005, and this filing will be effective on July 1, 2004, this effect needs to be reduced by 25%. Accordingly, our final estimate of the effect of the networks and independent medical reviews is a reduction of 6.2% of the medical portion of the advisory pure premium rate, or 3.7% of the overall advisory pure premium rate.

The combined impact of the networks, independent medical review process, and the "cleanup" legislation relating to the ACOEM Guidelines is 10.1% (6.2% + 3.9%) of the medical portion of the advisory pure premium rate, or 6.0% (3.7% + 2.3%) of the overall advisory pure premium rate.

Employer Liability for Immediate Medical Care

Senate Bill 899 amends Labor Code Section 5402 to provide that employers shall authorize medical treatment up to \$10,000 until liability for a claim is accepted or rejected. The amendment applies to injuries occurring on or after April 19, 2004.

The WCIRB estimates the additional cost by making several estimates. First, they assume that 5% of all claims are denied. Second, the WCIRB estimates that there are 650,000 new claims reported per year. Third, the WCIRB assumes that each denied claim will cost \$2,000, limited to \$10,000 per claim.

The WCIRB further assumes no behavioral changes, either the timing of denial of claims, the average medical care provided in the first 60 or 90 days, or the volume of filed claims.

With these assumptions, the calculation is a simple, straightforward multiplication, arriving at an increase in costs 0.7% of medical benefits or 0.4% of total benefits.

Mr. Neuhauser's calculation differs somewhat. He assumes that 7% of claims are denied and that 73% of these denials would be affected by the amended statute. (The resulting product of these two numbers is very close to the WCIRB's 5% estimate.) Mr. Neuhauser then multiplies by 7%, which he says is the proportion of total medical payments that is for treatments in the first 45 days. He says this number is based on a study he previously did on the primary treating physician presumption. The resulting 0.4% of medical is relatively close to the WCIRB's 0.7%.

It is not clear why Mr. Neuhauser chose 45 days. It would appear also that there is an implicit assumption that these eventually denied claims would generate the same treatment over this time as claims that are eventually accepted.

Because some of the details of Mr. Neuhauser's calculation are unclear and because he has not explicitly stated his assumptions, we reject his calculation in favor of the WCIRB's.

Medical-Legal Evaluations

Senate Bill 899 amendments to Labor Code Section 4060, 4061, 4062.1 and 4062.2 limit workers and employers to one medical-legal evaluation. The amendments become effective on injuries occurring on or after January 1, 2005.

The WCIRB calculates the savings by considering the proportion of claims involving separate medical-legal reports requested by at least two parties then assuming that one report is eliminated per claim. After considering that some claims show up in more than one category and eliminating the duplication, the WCIRB estimates a 14% savings.

A 14% savings on medical-legal costs would translate to a 0.2% savings in total benefit¹ costs.

Mr. Neuhauser estimates that the savings would be about 0.1% of total benefit costs. It is not clear what the exact basis for his estimate is, but it appears that he assumes fewer reports only for claims where the worker and the employer request separate reports and not for claims where other combinations of parties request separate reports, for example the primary treating physician and the employer.

On the whole, we find the WCIRB's estimate the more reliable and thus approve its recommendation.

EXPERIENCE RATING PLAN

Eligibility Threshold

Included in the WCIRB's filing is a decrease in the experience rating eligibility threshold that reflects the proposed decrease in pure premium. The purpose of the decrease is to maintain approximately the same volume of experience rated employers. This proposal is appropriate and the WCIRB is directed to revise the eligibility threshold to reflect the pure premium decrease approved by the insurance commissioner.

Effect of Immediate Medical Pay

The counsel for the public members of the WCIRB's governing committee, Mr. Arthur Levine, included in the record a letter raising some concern about the affect of the immediate medical care provision of SB 899 on experience modifications. Referring to the testimony of a broker, Mr. Gregory Osorio, Mr. Levine stated that while current law provides that non-compensable claims be excluded from experience rating, there should be a reference in the regulations to immediate medical care payments that are later determined to be part of a non-compensable claim. The WCIRB is directed to consider this matter and propose a change in the Experience Rating Plan at the next pure premium rate hearing.

MANDATORY RATE REDUCTION

Insurance Code Section 11735.1, which sunsets at the end of this year, currently requires all California workers' compensation insurers to submit a rate filing for policies incepting on or after January 1, 2004. That filing must contain a reduction of at least 7% from the insurers' current rates in order to comply with this Code section. Insurers that adopt the 7% or greater pure premium rate reduction with no additional changes or offsets will be granted an early effective date for all filings received prior to July 1, 2004, and the 30 day waiting period will be waived.

PROPOSED ORDER

WHEREFORE, IT IS ORDERED, by virtue of the authority vested in the Insurance Commissioner by California Insurance Code Sections 11734, 11750, 11750.3, 11751.5, and 11751.8 that Sections 2318.6 and 2353.1 of Title 10 of the California Code of Regulations are hereby amended and modified in the respects specified herein.

IT IS FURTHER ORDERED that the experience rating threshold be calculated to reflect the pure premium rate decrease adopted herein.

IT IS FURTHER ORDERED that these regulations shall be effective July 1, 2004 for all new and renewal policies with anniversary rating dates on or after that date.

IT IS FURTHER ORDERED that amended rating plans filed by insurers that contain only a change in multiplier to reflect the approved pure premium rate decrease adopted herein shall be effective upon filing with the commissioner.

I HEREBY CERTIFY that the foregoing constitutes my Proposed Decision and Proposed Order in the above entitled matter as a result of the hearing held before me as a Senior Staff Counsel of the Department of Insurance on April 29 and May 13, 2004, and I hereby recommend its adoption as the Decision and Order of the Insurance Commissioner of the State of California.

May 28, 2004

[Signed]

Larry C. White
Hearing Officer and Senior Staff Counsel